

Individualized Services Budget Cost Agreement

<b>DCF</b>	District Office: _____
	District Director: _____ Date: _____ Print Name: _____
	Placement Coord: _____ Date: _____ Print Name: _____
<b>CMHC</b>	Community Mental Health Center: _____
	Case Manager: _____ Date: _____ Print Name: _____
	Children's Coord: _____ Date: _____ Print Name: _____
	Business Manager: _____ Date: _____ Print Name: _____
	Tax ID Number: _____
<b>LEA</b>	LEA Supervisory Union: _____
	Local Signature: _____ Date: _____ Print Name: _____
	State Signature: _____ Date: _____ Print Name: _____
<b>OTHER</b>	Name of Agency: _____
	Authorized Signature: _____ Date: _____ Print Name: _____
	State Signature: _____ Date: _____ Print Name: _____
<b>LIT</b>	LIT Coordinator: _____ Date: _____ Print Name: _____
<b>DMH</b>	DMH-TCM Coordinator: _____ Date: _____ Print Name: _____
<b>FAMILY</b>	Parent Signature: _____ Date: _____
	Individual Served: _____ Date: _____

Child: \_\_\_\_\_ Date Submitted: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Period of Budget: \_\_\_\_\_ To \_\_\_\_\_ # of Mos.  
 Therapeutic Case Manager: \_\_\_\_\_  
 Submitting Agency: \_\_\_\_\_  
 Address: \_\_\_\_\_

MSR #: \_\_\_\_\_  
 Soc.Sec./Medicaid #: \_\_\_\_\_ Med (XIX) Eligible: 

Y	N	In Process
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 CMHC Child #: \_\_\_\_\_ SSI Eligible: \_\_\_\_\_  
 DCF #: \_\_\_\_\_ IV-E Eligible: \_\_\_\_\_

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